

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED FEB 10 1943

Registration District No. 1002

Primary Registration District No. 1002

Registrar's No. 371

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Luke's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 7 days  
(Specify whether  
In this community as above  
years, months or days)

3. (a) PRINT  
FULL NAME

Beauford Boyd Altic

3. (b) If veteran,  
name war no.

3. (c) Social Security  
No. 495-10-7422

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married,  
divorced Married

6. (b) Name of husband or wife Doris Altic 6. (c) Age of husband or wife if  
alive Unknown years

7. Birth date of deceased October 12 1902  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
40 3 10 hr. min.

9. Birthplace Illinois  
(City, town, or county) (State or foreign country)

10. Usual occupation Plumbing Supplies

11. Industry or business X

12. Name James Robert Altic

13. Birthplace Illinois  
(City, town, or county) (State or foreign country)

14. Maiden name LU ELLA Dyer  
(City, town, or county) (State or foreign country)

15. Birthplace Illinois  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Doris Altic

(b) Address North Kansas City, Mo.

17. (a) Burial (b) Date thereof 1-25-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Scott Valley Cemetery

18. (a) Signature of funeral director Stine & McClure

(b) Address 3235 Gillham Plaza, K. C. Mo.

19. (a) 1-25-43 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clay  
(c) City or town North Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. R. F. D. #8  
(If rural, give location)  
(e) Citizen of foreign country? NO. (Yes or No)  
If yes, name country X

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 22nd  
year 1943 hour 8:05 minute P. M.

21. I hereby certify that I attended the deceased from Feb. 1942  
to Jan 22 1943  
that I last saw him alive on Jan 22 - 1943 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Uremia Duration 3ds  
Due to Chronic Glomerulonephritis 1yr.  
Due to 1218

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy Chronic Nephritis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature F. Chawo (M. D. or other)  
Address 324 1st St. Bldg Date signed Jan 25

Dr. Lamar

94-8-3

Charlottesville, VA

830

### STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed \_\_\_\_\_

Licensed Embalmer No. 1445

P. O. Address \_\_\_\_\_

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

If this body is not embalmed, fact should be so stated above.